		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042838

Facility Name: CEDAR RIDGE HEALTHCARE CENTER

Address: ONE PERRYMAN STREET (Number) LEBANON (City) 62254 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 537-6165 **Fax #** (618) 537-4021

HFS ID Number: 363918503002

Date of Initial License for Current Owners: 01/01/94

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[X] PROPRIETARY		[ ] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: CATHY STORR **Telephone Number:** (714) 689-0300

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) CATHY STORR, PRINCIPAL

(Firm Name & Address) KELLOGG & ANDELSON ACCOUNTANCY CORPORAT, 3200 PARK CENTER DRIVE # 750 COSTA MESA, CA 9262

(Telephone) (714) 689-0300 Fax # (714) 689-0311

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	114	Skilled (SNF)	114	41,610	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	114	TOTALS	114	41,610	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,924	13,419	9,347	39,690	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,924	13,419	9,347	39,690	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.39%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 6,019

Medicare Intermediary ADMINISTAR FEDRAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	164,649	31,748	12,775	209,172		209,172		209,172			1
2	Food Purchase		182,159		182,159		182,159		182,159			2
3	Housekeeping	131,483	12,027	18,457	161,967		161,967		161,967			3
4	Laundry	43,506	13,062	7,012	63,580		63,580		63,580			4
5	Heat and Other Utilities			114,047	114,047		114,047		114,047			5
6	Maintenance	48,468	25,251	21,992	95,711		95,711		95,711			6
7	Other (specify):*											7
8	TOTAL General Services	388,106	264,247	174,283	826,636		826,636		826,636			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,683,752	115,426	35,157	1,834,335		1,834,335	7,138	1,841,473			10
10a	Therapy		3,986	667,883	671,869		671,869	53,236	725,105			10a
11	Activities	84,816	6,701	7,639	99,156		99,156		99,156			11
12	Social Services	30,630	2,054	4,266	36,950		36,950		36,950			12
13	CNA Training											13
14	Program Transportation			8,609	8,609		8,609		8,609			14
15	Other (specify):*							22,946	22,946			15
16	TOTAL Health Care and Programs	1,799,198	128,167	729,554	2,656,919		2,656,919	83,320	2,740,239			16
	C. General Administration											
17	Administrative	108,036		260,436	368,472		368,472	(29,849)	338,623			17
18	Directors Fees											18
19	Professional Services			2,871	2,871		2,871		2,871			19
20	Dues, Fees, Subscriptions & Promotions			540	540		540	(540)				20
21	Clerical & General Office Expenses	224,457	22,281	173,404	420,142		420,142	(88,998)	331,144			21
22	Employee Benefits & Payroll Taxes			489,267	489,267		489,267		489,267			22
23	Inservice Training & Education											23
24	Travel and Seminar			28,027	28,027		28,027		28,027			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,318	81,318		81,318		81,318			26
27	Other (specify):*											27
28	TOTAL General Administration	332,493	22,281	1,035,863	1,390,637		1,390,637	(119,387)	1,271,250			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,519,797	414,695	1,939,700	4,874,192		4,874,192	(36,067)	4,838,125			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER #0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,653	28,653		28,653		28,653			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			114,989	114,989		114,989	(112,267)	2,722			32
33	Real Estate Taxes			48,328	48,328		48,328		48,328			33
34	Rent-Facility & Grounds			434,802	434,802		434,802		434,802			34
35	Rent-Equipment & Vehicles			11,534	11,534		11,534		11,534			35
36	Other (specify):*							22,932	22,932			36
37	**TOTAL Ownership**			638,306	638,306		638,306	(89,335)	548,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		214,094	19,305	233,399		233,399		233,399			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,415	62,415		62,415		62,415			42
43	Other (specify):*		33,429		33,429		33,429		33,429			43
44	**TOTAL Special Cost Centers**		247,523	81,720	329,243		329,243		329,243			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,519,797	662,218	2,659,726	5,841,741		5,841,741	(125,402)	5,716,339			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(318)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,022)	21		13
14	Non-Care Related Interest	(111,949)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,958)	21		24
25	Fund Raising, Advertising and Promotional	(14,679)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	7,069			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (193,857)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	68,455		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 68,455		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,402)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
CEDAR RIDGE HEALTHCARE CENTER
ID# 0042838
Report Period Beginning: 01/01/05
Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dues and Subscriptions	$ (540)	20	1
2	Bank Charges	(366)	21	2
3	Public Relations	(15,825)	21	3
4	Patient Theft and Loss	(1,292)	21	4
5	Prior Year Expense	16,918	21	5
6	Prior Year Litigation	226	21	6
7	Other Revenue	0	21	7
8	Prior Year Revenue	0	21	8
9	Bonus Under-Accrual	7,948	17	9
10	Director of Nursing Bonus	(7,138)	17	10
11	Director of Nursing Bonus	7,138	10	11
12	Depreciation Reconciliation	0	30	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	7,069		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER **#** 0042838 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	7,138	0	0	0	0	0	0	0	0	0	0	7,138	10
10a	Therapy	0	0	53,236	0	0	0	0	0	0	0	0	53,236	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	22,946	0	0	0	0	0	0	0	0	0	22,946	15
16	**TOTAL Health Care and Programs**	7,138	22,946	53,236	0	0	0	0	0	0	0	0	83,320	16
	C. General Administration													
17	Administrative	810	(30,659)	0	0	0	0	0	0	0	0	0	(29,849)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(540)	0	0	0	0	0	0	0	0	0	0	(540)	20
21	Clerical & General Office Expenses	(88,998)	0	0	0	0	0	0	0	0	0	0	(88,998)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(88,728)	(30,659)	0	0	0	0	0	0	0	0	0	(119,387)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,590)	(7,713)	53,236	0	0	0	0	0	0	0	0	(36,067)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER **#** 0042838 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(112,267)	0	0	0	0	0	0	0	0	0	0	(112,267)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	22,932	0	0	0	0	0	0	0	0	0	22,932	36
37	**TOTAL Ownership**	(112,267)	22,932	0	0	0	0	0	0	0	0	0	(89,335)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(193,857)	15,219	53,236	0	0	0	0	0	0	0	0	(125,402)	45

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
COVENANT CARE INC.	100	SEE ATTACHED	SEE ATTACHED			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	15	HO Alloc Direct Care	$	Covenant Care Inc.	100.00%	$ 22,946	$ 22,946	1
2	V	17	HO Alloc Indirect Care	260,436	Covenant Care Inc.	100.00%	229,777	(30,659)	2
3	V	36	HO Alloc Capital Amount		Covenant Care Inc.	100.00%	22,932	22,932	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 260,436			$ 275,655	$ * 15,219	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Physical Therapy	$ 317,248	Select Therapy		$ 343,266	$ 26,018	15
16	V	10a	Occupational Therapy	225,032	Select Therapy		243,488	18,456	16
17	V	10a	Speech Therapy	106,839	Select Therapy		115,601	8,762	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 649,119			$ 702,355	$ * 53,236	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Care Inc.
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949) 349-1200
Fax Number: (949) 349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	15	HO Alloc Direct Care	accumulated cost			$	$		$ 22,946	1
2	17	HO Alloc Indirect Care	accumulated cost						229,777	2
3	36	HO Alloc Capital Amount	accumulated cost						22,932	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 275,655	25

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Select Therapy
Street Address: 27071 Aliso Creek Road
City / State / Zip Code: Aliso Viejo, CA 92656
Phone Number: (949) 349-1200
Fax Number: (949) 349-1900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Physical Therapy				$	$		$ 343,266	1
2	39	Occupational Therapy							243,488	2
3	39	Speech Therapy							115,601	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 702,355	25

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Banque Paribas		X	Facility Acquisition		02/03/98	$ 1,974,000	$ (1,974,000)	6/03	various	$ 114,989	1
2	Less: non-care portion										(111,949)	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,974,000	$ (1,974,000)			$ 3,040	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,974,000	$ (1,974,000)			$ 3,040	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ n/a Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 48,328	2
3. Under or (over) accrual (line 2 minus line 1).		$ 48,328	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,328	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	42,525	8
	2001	43,589	9
	2002	42,810	10
	2003	48,247	11
	2004	45,608	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CEDAR RIDGE HEALTHCARE CENTER COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0042838

CONTACT PERSON REGARDING THIS REPORT Cathy Storr

TELEPHONE (714) 689-0300 FAX #: (714) 689-0311

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-24.0-407-005	Long Term Care	$	$ 45,608.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$ 45,608.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,852 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	1,680		20			1,680	9
10	Various			1997	11,984		20			11,984	10
11	Various			1998	9,288		20			9,288	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Related Party Allocations								68
69	Financial Statement Depreciation			891			(891)		69
70	TOTAL (lines 4 thru 69)		$ 22,952	$ 891		$	$ (891)	$ 22,952	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 22,952	$ 891		$	$ (891)	$ 22,952	1
2	Wallpaper	1999	1,538		20			1,538	2
3	Cove Base	1999	136		20			136	3
4	Wallpaper & supplies	1999	1,398		20			1,398	4
5	Install 911 dialer & connect alarm system	1999	485		20			485	5
6	Install 3 additional systems telephones	1999	387		20			387	6
7	Reprogram system for proper operation	1999	289		20			289	7
8	Install 32 thermostatic control mixing valves	1999	607		20			607	8
9	A/C condenser ($63 credit memo in 5/99)	1999	1,012		20			1,012	9
10	4 HVAC's	1999	2,306		20			2,306	10
11	Install required cabling from time-clock to hub	1999	347		20			347	11
12	Evaluation	1999	105		20			105	12
13	Install network media & outlets per quotation	1999	1,328		20			1,328	13
14	BTU Heat/Cool Units 2	1999	1,234		20			1,234	14
15	Set up of amster key system for entire facility	1999	2,743		20			2,743	15
16	Crack seal restripe Parking Lot	1999	2,200		20			2,200	16
17	Receiver system	1999	1,544		20			1,544	17
18	Alarm transmitters	1999	149		20			149	18
19	Exhuast fan repair	1999	464		20			464	19
20	Installed 2 smoke detectors	1999	470		20			470	20
21	professional services	2000	4,525		20			4,525	21
22	4 AC/heat units	2000	2,292		20			2,292	22
23	Repaired network line	2000	146		20			146	23
24	Reinstalled Network Line	2000	1,487		20			1,487	24
25	Just Ask Rental	2000	19		20			19	25
26	Repaired network line	2000	45		20			45	26
27	repaired a/c unit	2000	1,840		20			1,840	27
28	renovation on alzheimer unit	2000	173		20			173	28
29	renovation on alzheimer unit	2000	165		20			165	29
30	install computer network cable	2000	352		20			352	30
31	nurse call system services	2000	432		20			432	31
32	set up computer network in alz unit	2000	92		20			92	32
33	stabilize corner of facility	2000	1,300		20			1,300	33
34	TOTAL (lines 1 thru 33)		$ 54,562	$ 891		$	$ (891)	$ 54,562	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 54,562	$ 891		$	$ (891)	$ 54,562	1
2	Stabilize corner of facility	2000	2,605		20			2,605	2
3	mixing valves	2001	1,035		20			1,035	3
4	new doors for the res dining room	2001	690		20			690	4
5	call light system for alz unit	2001	2,087		20			2,087	5
6	new carpet	2001	2,343		20			2,343	6
7	64 windows	2001	5,915		20			5,915	7
8	4 heat/cool units	2001	2,221		20			2,221	8
9	alz unit- door lock system	2001	1,707		20			1,707	9
10	mixing valves	2001	547		20			547	10
11	new tv antenna system	2001	1,896		20			1,896	11
12	a/c unit	2001	555		20			555	12
13	drapery and curtains	2001	9,014		20			9,014	13
14									14
15	Dietary Equipment	2002	3,398		20			3,398	15
16	replace parts for boiler	2002	648		20			648	16
17	concrete for sidewalks	2002	995		20			995	17
18	a/c heat units	2002	3,189		20			3,189	18
19	alzheimer unit	2002	77,976		20			77,976	19
20	rehab unit	2002	10,667		20			10,667	20
21	a/c unit	2002	1,750		20			1,750	21
22	Wall Carpeting	2002	1,376		20			1,376	22
23	5 a/c units	2003	814		20			814	23
24	5 a/c units	2003	2,028		20			2,028	24
25	Carpeting	2003	808		20			808	25
26	5 a/c units	2003	2,842		20			2,842	26
27	Door for outpatient therapy room	2003	516		20			516	27
28	A/C Unit, Labor, Parts	2003	2,201		20			2,200	28
29	Flagpoles for entrance	2003	3,888		20			3,888	29
30	Reroof facility & out buildings	2003	60,321		20			60,321	30
31	Reimb from HUD	2003	(48,926)		20			(48,926)	31
32	Collinvile Ice & Fuel Co	2003	762		20			762	32
33	Repair Damanged Water Heater	2003	1,015		20	(6)	(6)	1,015	33
34	TOTAL (lines 1 thru 33)		$ 211,444	$ 891		$ (6)	$ (897)	$ 211,444	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 211,444	$ 891		$ (6)	$ (897)	$ 211,444	1
2	A/C Units (6)	2003	3,335		20			3,335	2
3	Drapes	2003	7,430		20	(1,486)	(1,486)		3
4	Reroof facility & out buildings	2003	(9,613)		20			(9,613)	4
5									5
6	Drapes	2004	(7,430)		5	1,362	1,362		6
7	Insinkerator	2004	878		5	176	176	293	7
8	5 A/C heating units	2004	2,797		5	559	559	932	8
9	Drapes & rods	2004	1,286		5	257	257	407	9
10	Drapes & rods	2004	6,298		5	1,260	1,260	1,994	10
11	Hot water heater	2004	4,912		5	982	982	1,555	11
12	Keypad Code Alarm	2004	849		5	170	170	255	12
13	Landscaping/Concrete	2004	1,143		5	229	229	286	13
14	Landscaping/Concrete	2004	1,414		5	283	283	353	14
15	Refund from Ins. Co.	2004	(17,759)		5	(3,552)	(3,552)	(4,440)	15
16									16
17	Albers Fire Port Equipment	2005	3,436		5	458	458	458	17
18	United Technologies Carrier	2005	1,585		5	132	132	132	18
19	Sigman Heating & Air	2005	1,789		5	30	30	30	19
20	Sigman Heating & Air	2005	2,758		5	46	46	46	20
21	Grainger	2005	(525)		5	(9)	(9)	(9)	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 216,027	$ 891		$ 891	$ (0)	$ 207,459	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 135,035	$ 19,524	$ 19,524	$	10	$ 113,785	71
72	Current Year Purchases	129,825	8,238	8,238		10	8,238	72
73	Fully Depreciated Assets	97,155				10	97,155	73
74								74
75	TOTALS	$ 362,015	$ 27,762	$ 27,762	$		$ 219,178	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 Chevy Passenger Van	1999	$ 35,966	$	$	$	5	$ 35,966	76
77										77
78										78
79										79
80	TOTALS			$ 35,966	$	$	$		$ 35,966	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 614,008	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,653	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 28,653	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 462,603	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in progress	$ (0)	92
93			93
94			94
95		$ (0)	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wentz Health Care
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1986	114		$			3
4	Additions							4
5								5
6								6
7	TOTAL		114		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☒ X NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 449,177
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 11,534 Description: See supplemental page 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 225,032	$		$ 225,032	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			318,248			318,248	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				214,094		214,094	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Equipment Rental	39					19,305		19,305	13
14	TOTAL			$		$ 543,281	$ 233,399		$ 776,680	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER **#** 0042838 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,000	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	364,002		3
4	Supply Inventory (priced at)	52,064		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,162		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 423,228	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	216,024		15
16	Equipment, at Historical Cost	362,580		16
17	Accumulated Depreciation (book methods)	(426,635)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	201,196		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 353,165	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 776,393	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (11,061)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	179,909		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE PAGE 17.1	1,318,355		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,487,203	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SEE PAGE 17.1	1,974,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,974,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,461,203	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,684,810)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 776,393	$	48

***(See instructions.)**

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,955,743)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,955,743)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	270,933	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 270,933	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,684,810)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,188,117	1
2	Discounts and Allowances for all Levels	(830,390)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,357,727	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,017,778	6
7	Oxygen	11,197	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,028,975	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	525,231	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,004	19
20	Radiology and X-Ray	22,942	20
21	Other Medical Services	162,924	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 738,101	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	318	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 318	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Page 19.1	(3,090)	28
28a	See Supplemental Page 19.1	(9,357)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (12,447)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,112,674	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	826,638	31
32	Health Care	2,656,919	32
33	General Administration	1,390,635	33
	B. Capital Expense		
34	Ownership	638,306	34
	C. Ancillary Expense		
35	Special Cost Centers	266,828	35
36	Provider Participation Fee	62,415	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,841,741	40
41	**Income before Income Taxes (line 30 minus line 40)****	270,933	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 270,933	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,081	2,123	$ 67,733	$ 31.90	1
2	Assistant Director of Nursing	1,712	1,712	40,220	23.49	2
3	Registered Nurses	7,171	7,293	142,657	19.56	3
4	Licensed Practical Nurses	29,865	30,372	535,826	17.64	4
5	CNAs & Orderlies	75,074	76,349	930,543	12.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,115	4,115	50,699	12.32	9
10	Activity Assistants	1,857	1,953	26,341	13.49	10
11	Social Service Workers	2,818	2,866	38,406	13.40	11
12	Dietician					12
13	Food Service Supervisor	1,891	1,891	31,540	16.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,409	15,563	133,109	8.55	15
16	Dishwashers					16
17	Maintenance Workers	2,208	2,401	48,468	20.19	17
18	Housekeepers	14,624	15,016	131,483	8.76	18
19	Laundry	5,572	5,581	43,506	7.80	19
20	Administrator	1,983	1,983	108,036	54.48	20
21	Assistant Administrator					21
22	Other Administrative	9,609	9,689	145,452	15.01	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,963	1,988	23,746	11.94	27
28	Qualified MR Prof. (QMRP)	2,009	2,025	22,032	10.88	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,961	182,920	$ 2,519,797 *	$ 13.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	207.75 plus mi	$ 7,922		35
36	Medical Director	monthly	6,000		36
37	Medical Records Consultant	22	880		37
38	Nurse Consultant		0		38
39	Pharmacist Consultant	monthly	3,208		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	64.21 plus mileag	2,715		44
45	Social Service Consultant	97.875 plus milea	4,266		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	22	$ 24,991		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Altobella	Executive Director		$ 108,036
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 108,036

B. Administrative - Other

Description	Amount
Management Fee-Covenant Care Inc.	$ 260,436
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 260,436

C. Professional Services

Vendor/Payee	Type	Amount
GEN. ADMIN. PHYSICIAN SERVICES		$ 2,871
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 2,871

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,466
Unemployment Compensation Insurance	36,622
FICA Taxes	184,168
Employee Health Insurance	181,144
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Employer Contributions/Other Benefits	12,868
TOTAL (agree to Schedule V, line 22, col.8)	$ 489,267

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues and Subscriptions	540
Disallowed Dues and Subscriptions	(540)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,863
In-State Travel	8,117
Seminar Expense	17,047
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,027

**See instructions.

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CEDAR RIDGE HEALTHCARE CENTER # 0042838 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **408** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **62,415**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **NO** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **ERNST & YOUNG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **AUDIT NOT SPECIFIC TO FACILI**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Facility Name: **Cedar Ridge** **Report Period:** **Beginning:** **1/1/2005**
ID# **0042838** **Ending:** **12/31/2005**

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expenses - Line 7	Amount	
Not Applicable		
	0	

Other - Line 15	Amount	
HO Alloc Direct Care	22,946	< adjustment is on page 6
	22,946	

Health Care Programs - Line 16	Amount	
Not Applicable		
	0	

General & Administrative - Line 27	Amount	
Not Applicable		
	0	

Inservice Education - Line 23 - Use if more than $2,000	Amount	
	0	

STATE OF ILLINOIS

Facility Name: **Cedar Ridge** **Report Period:** **Beginning: 1/1/2005**
ID# **0042838** **Ending: 12/31/2005**

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership Costs - Line 36	Amount	
HO ALLOC CAPITAL AMOUNT	22,932	<Adjustment, can be found on page 6
Total Page 4 / Line 36 / Column 8 ----->	22,946	

Special Cost Centers - Line 43	Amount
LABORATORY PURCHASED SERVICES	14,111
RADIOLOGY MEDICAL SUPPLIES	0
RADIOLOGY PURCHASED SERVICES	19,318
Total Page 4 / Line 43 / Column 8 ----->	33,429

Cedar Ridge
STATE OF ILLINOIS ID: 0042838
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REPORTING PERIOD: Beginning: 1/1/2005 Ending: 12/31/2005

Lease Expense - Non-Medical Equipment	-
Lease Expense - Vehicles	11,534
TOTAL	11,534
Reconcile with schedule V, line 35, column 8:	11,534 (page 4, line 35, col 8)
DIFFERENCE	-

STATE OF ILLINOIS
Facility Name: Cedar Ridge **Report Period:** **Beginning:** 1/1/2005
ID# **0042838** **Ending:** 12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

OTHER CURRENT ASSETS:	AMOUNT
PLEDGES & REC - OTHER RECEIVABLES	0
TOTAL	0
Reconcile with schedule XV, line 9:	0

Difference: 0

OTHER CURRENT LIABILITIES:	AMOUNT
OTHR ACCRD LIAB - GEN LIAB 2001	0
OTHR DEFRRD CRED UNEARNED REV-PREBIL	-13,587
INTERCOMPANY	-1,304,769
	-1,318,355
Reconcile with schedule XV, line 36:	-1,318,355

Difference: 0

OTHER NON-CURRENT ASSETS:	
CONSTRUCTION-IN-PROGRESS	6,000
REAL ESTATE ESCROW DEPOSIT	16,082
INSURANCE ESCROW DEPOSIT	24,449
REPLACEMENT RESERVES	154,840
FACILITY FUND ACCOUNT	-175
	201,196
Reconcile with schedule XV, line 23:	201,196

Difference: 0

OTHER NON-CURRENT LIABILITIES:	
OTHR NONCURR - BANQUE PARIBAS-SR DEBT	-1,974,000
	-1,974,000
Reconcile with schedule XV, line 43:	-1,974,000

Difference: 0

STATE OF ILLINOIS

Facility Name: **Cedar Ridge** **Report Period:** **Beginning:** **1/1/2005**
ID# **0042838** **Ending:** **12/31/2005**

SUPPLEMENTAL SCHEDULE OF REVENUES

DESCRIPTION	Amount
MISC. REV. OTHER REVENUE	3,090

		Total from Schedule XVII, line 28	Difference
TOTALS	3,090	3,090	0

DESCRIPTION	Amount
MISC. REV. PRIOR YEAR REVENUE	9,357

		Total from Schedule XVII, line 28a	Difference
TOTALS	9,357	9,357	0

Cedar Ridge

PROVIDER PARTICIPATION FEES

REPORTING PERIOD: Beginning: 1/1/2005 Ending: 12/31/2005

PROVIDER PARTICIPATION FEE PER WTB (schedule V, line 42, Column 8)	62,415
BED DAYS X $1.50 (114 Beds X 365 Days)	62,415
UNDETAILED AMOUNT	0